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fundamental principles of emergency medicine is to assume the worst first and rule out serious or life-threatening illnesses?

A. Yes.

Q. And why would you want to do that?

A. If somebody has something that is, quote, the worst, then you would want to see if you can do something to diagnose and treat it.

Q. Okay. And is subarachnoid hemorrhage something that's treatable?

A. Not always.

Q. Well, in the experience that you have described, that is, the three patients that you saw back in 2005 -- I don't know what happened to the patient that was obtunded, but at least two of them were treated. Is that correct?

A. That's true.

Q. Okay. So --

A. It kind of is -- but treating, I mean, there's -- is it curable? Is it -- can you change the natural history of it? Can I treat it? And my treatment might be to provide comfort measures for somebody who is going to die. My treatment might be to diagnose and provide oxygen and talk to the neurosurgeon.

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Q. Okay.

A. So there's a whole spectrum of disease, and not all of it would be treatable or curable, if that's what you mean.

Q. Okay. And maybe that's not -- maybe I didn't ask it very well. But I'm just curious: Is subarachnoid hemorrhage -- is it never treatable?

A. Of course not. There's a number of cases which are treatable.

Q. So there's a significant number of cases of patients who have a subarachnoid hemorrhage that are treatable. Is that correct?

A. Yes.

Q. And are you aware of patients with subarachnoid hemorrhage who are treated who have a good outcome?

A. Yes.

Q. And we have been talking about headaches. Is it a classic symptom of a subarachnoid hemorrhage that somebody would have a severe headache?

A. Yes.

Q. And that it would be a sudden onset?

A. Yes.

Q. Is a common associated symptom of a subarachnoid hemorrhage nausea and vomiting?

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A. Yes.

Q. Would you agree that -- at least in the literature, that a majority of the patients that present with a subarachnoid hemorrhage who have been bled -- started bleeding in the past 24 hours don't have neck stiffness?

A. I'm not sure that that's true. Anytime that the blood goes down and irritates the meninges and starts to travel down the neck -- now, they may not have rigidity, they may not be as rigid as a board, but at least, in my experience - and I think it's probably borne out - is that if they have sufficient blood to cause symptoms and they've had sufficient time for it to develop, then they probably have some degree of meningismus, some degree of neck discomfort with movement.

Q. Okay. Neck discomfort with movement, but not necessarily neck rigidity? I want to make sure I understand it.

A. Yeah. I -- and the patients that I saw don't -- they were not board stiff as if they had meningitis or something like that. These are people that if you moved their neck, it hurt them. But it wasn't the most excruciating thing. It didn't cause them to become board-like, but it was -- it was a

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finding.

Q. Okay.

A. It was not -- these people, most recently, I could not easily move their head back and forth without them saying, "That's uncomfortable for me."

Q. Okay. And what texts -- I'm curious. There's been some discussion about emergency room textbooks. Is there -- is there any text that you use that you refer to in your practice?

A. Not much anymore, honestly.

Q. All right.

A. I mean, I have specific things that I go to, a source of information, like just in terms of my focus, practice. But I rarely use the typical Tintinalli or Peter's book or those for much, except for maybe procedural issues of where to -- what landmarks you use for a procedure or something like that.

Q. Okay. And how about Rosen's --

A. Peter Rosen's book.

Q. Peter -- okay. Sorry. I didn't understand that. So Peter -- you're familiar with Peter Rosen's text on emergency medicine. Is that right?

A. Yes.

Q. And Tintinalli's text on emergency

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Q. All right. And so -- and at least in terms of the notes that you would expect to be taken about a patient, it's going to be different on the UCC side as opposed to the ER side. Is that right?

A. Yes.

Q. Okay. What other differences would you expect between the ER side, where you're seen by a physician, and the UCC side, where you're seen by a mid-level practitioner?

A. I would assume the patients would be sicker.

Q. Okay. And -- and is there an expectation that -- that the patients would -- certainly there would be an expectation that the patients are sicker if they go to the ER side versus the UCC side. Is that correct?

A. Yes.

Q. Okay. And so sometimes -- so if you're working as a mid-level practitioner -- scratch that.

If you're an ER physician -- the physician -- the physicians that are -- sorry. It is getting late.

If you're an ER physician working at ANMC, or in any facility where patients are triaged to mid-level practitioners is versus ER physicians, if you're the physician, you're going to expect to see

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patients that are sicker. Is that right?

A. Yes.

Q. All right. You said, "Overall her clinic note is sparse." And what do you mean by that?

A. There's -- you know, I meant that there's not a lot in that note.

Q. Right. Go ahead. I didn't mean to cut you off. It looked like you were going to say something else.

A. No, no.

Q. There's not a lot in that note.

A. It's very focused.

Q. It's very focused on ear and jaw pain. Is that right?

A. Yes.

Q. Okay. And do you think that, where it says "ear/jaw pain," do you think that's consistent with "ears and head are hurting, up all night"?

A. It's different.

Q. Okay. If you were seeing a -- a patient who was triaged to you, that is, you're the physician, you're seeing a patient who is triaged to you with "ears and head are hurting, up all night," ten out of ten pain, would you be suspicious of a -- and they've got a -- and they're a chronic pain

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patient. Would you -- would it be -- part of your differential diagnosis would be that this person could potentially have a -- a bleed?

A. Those kinds of things, looking for every extreme case, always go through my mind in the most prosaic situations.

Q. When you say, "the most prosaic situations," what do you mean?

A. With every child with a runny nose and an earache, I always think about the possibility of meningitis or an AV malformation or something completely crazy. I have not found one yet, but that's sort of what we do.

Q. And that's sort of what you do; that is, that's your function in the emergency room as an emergency room physician. Is that correct?

A. Yes.

Q. And do you think that that function, that is, you know, thinking about the worst-case scenario in even the most prosaic cases, that that's also the function of somebody working at the UCC?

A. Should be.

Q. All right. So my question was: If this patient, a chronic pain patient, presented to you, "ears and head are hurting, up all night," ten out

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of ten pain, it would be included within your differential diagnosis that this person could have a bleed. Is that correct?

A. Yes.

Q. All right. And how would you rule that out?

A. By talking with them.

Q. And getting a history?

A. Yes.

Q. Would you want to know whether or not the pain was different than the pain they had before?

A. Yes, I would.

Q. Okay. And would you want to know whether or not it was the worst pain they ever had?

A. Yes.

Q. Okay. And would you want to know how -- how the pain started and whether or not it was abrupt?

A. Yes.

Q. Okay. Anything else that you would want to know?

A. Oh, I would want to know if they ever had anything like it before, if there were any unusual features to it. I would want to know if they were having fevers, have there been any trauma recently.

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Q. Okay. And would you want to know if they were -- if you knew they were taking pain medications, would you want to know how much?

A. If -- with a person that was on chronic pain management, I would ask them maybe when they had their last dose, but I probably wouldn't be very interested at all in how much they had taken.

Q. Would you be interested in all whether -- at all in whether or not their pain was usually controlled by pain medication?

A. Yeah. I would want to know what they thought had changed, if they're having break-through pain.

Q. Okay. Is there anywhere documented on this note and -- and is Donna Fearey -- scratch that.

Is there anywhere documented in this note that Donna Fearey determined whether or not this was the worst pain this patient had ever had?

A. No.

Q. And is there anywhere documented in this note whether or not this was pain that was different in nature and quality than what the patient had had before?

A. No.

Q. Can you tell from her note how much pain

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medication he had had?

A. No. I would just concede that she recognized that he was taking Percocet, but there's no mention made of how much.

Q. Or how much he vomited that night?

A. No.

Q. In her note where she says, "speech slow," what do you understand that to mean?

A. I didn't know what to mean from it, from looking at this note initially. And it was of concern to me if it meant something focal.

In reading her deposition, what it meant to her, when she wrote it, from what I could tell, was that she was saying that he seemed to be in no significant distress, that he was speaking slowly, he wasn't pressured.

Q. Does that make any sense to you, that you would document that a patient is speaking normally by saying that their speech is slow?

A. Well, I can't speak to what -- how other people would, you know, try to document something. I can say that we often, in emergency medicine, try to put something in that allows a person to get a picture of the person we're seeing.

And in reading her deposition and putting

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this in context, that was what I understood her to be doing, which was to say I considered the possibility this person has something else going on. I considered the possibility that this patient's ten out of ten pain means the same to him as it does to me. And at this point in time, the person seems relatively comfortable.

Q. And that's what "speech slow" means to you? I mean, is that what you take from that?

A. It wasn't when I first read it. But once I read her deposition, that was my understanding, was that she was trying to infer that he was speaking in a slow and controlled fashion.

Q. Is that reasonable to you? I mean, does that seem like a reasonable way to document that?

A. It's not the way I would do it, but it's how she chose to document it.

Q. I know. But is that how the way -- have you ever seen normal speech documented that way?

A. When I say that people -- the answer is: I'm not sure I have. But to elaborate on that, when I say this is a sparse note, I don't know how much opportunity you've had to look at people's clinic notes, they are very telegraphic.

When I do a note in the emergency department,

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I dictate everything I see, from the most minuscule to the major cases. And as a consequence, it's much easier, honestly, to expand on things.

When you're doing written notes, you tend to have less documentation. So honestly, I -- I think the written notes are kind of inferior, and they lend themselves to not putting as much in as you should.

Q. And certainly this note, as you say, is sparse, there's not a lot of information in there as -- as you just -- as you stated previously. And so would you expect her to at least document things that she felt were clinically significant?

A. She put on the side, "no fever, no chills." I can't -- what does that other one say? I don't have her typed thing. And no abdominal pain, I think, is the other one or something. So she did list some pertinent negatives on the side.

Q. Well, could "speech slow" also be a -- an indication that the person had a neurological deficit?

A. When I first read this thing, when I was being asked to look at this case, that was a significant concern to me. When I read her explanation of why she wrote the way she did, I took her -- what she said as why she put it that way.